PRINTED: 06/10/2021
FORM APPROVED
Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TN2802	A. BUILDING _____ B. WING _____	06/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AHC MEADOWBROOK	1245 E COLLEGE ST PULASKI, TN 38478

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments An annual recertification survey and investigation of complaint TN00053366 was conducted on 6/7/2021-6/9/2021 at AHC Meadowbrook. Health deficiencies were not citied in relation to the recertification survey and TN00053366 under Chapter 1200-8-6, Standards for Nursing Homes.	N 000		

Division of Health Care Facilities
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jennifer M. Rayner TITLE: Administrator (X6) DATE: 6-25-2021

STATE FORM 6899 G89X11 If continuation sheet 1 of 1